



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Physician Management Services

**Respondent Name**

Indemnity Insurance Company of North America

**MFDR Tracking Number**

M4-17-1173-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

December 30, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The insurance company has not paid the CPT code 97546. I attempted to settle dispute but the carrier still has not paid the claim correct."

**Amount in Dispute:** \$1,216.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier is currently auditing the medical bills ... at issue in this dispute. Payment will be issued pursuant to the fee guidelines."

**Response Submitted by:** Downs-Stanford, P.C.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12 – 14, 2016	Work Hardening Program	\$1,216.00	\$1,216.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008, until September 1, 2016.
4. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 309 – The charge for this procedure exceeds the fee schedule allowance.
  - 96 – Non-covered charge(s).

- P12 – Workers compensation jurisdictional fee schedule adjustment.
- 203 – Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.
- 216 – Based on the findings of a review organization.
- 5280 – No additional reimbursement allowed after review of appeal/reconsideration
- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- W3 – Additional payment made on appeal/reconsideration.
- 247 – A payment or denial has already been recommended for this service.
- B13 – Previously paid. Payment for this claim/service may have been provided in previous payment.
- 5225 – Procedure/services are disallowed as they are not authorized.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

### **Issues**

1. Does a medical necessity issue exist for this dispute?
2. Is Indemnity Insurance Company of North America's denial of date of service July 12, 2016, as a non-covered service supported?
3. Is Indemnity Insurance Company of North America's denial of dates of service July 13 and 14, 2016, for no preauthorization supported?
4. Is Physician Management Services entitled to additional reimbursement for the services in question?

### **Findings**

1. 28 Texas Administrative Code §133.307(a)(2) limits the authority of the division to resolve medical fee disputes to "health care determined to be medically necessary and appropriate for treatment of a compensable injury." On reconsideration, Indemnity Insurance Company of North America (Indemnity Insurance Company) denied July 12, 2016, disputed services with claim adjustment reason codes 203 – "PEER REVIEW HAS DETERMINED – PAYMENT FOR TREATMENT HAS NOT BEEN RECOMMENDED DUE TO THE LACK OF MEDICAL NECESSITY. PEER REVIEW HAS PROVIDED ITS FINDINGS TO THE PROVIDER IN PRIOR DOCUMENTATION," and 216 – "BASED ON THE FINDINGS OF A PEER REVIEW."

28 Texas Administrative Code §133.240(b) states, in relevant part, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title."

Submitted documentation includes a letter from Physician based Medical Management dated July 7, 2016. The letter provides preauthorization for a work hardening program of 80 hours/units for the left elbow injury. Because it is inappropriate for Indemnity Insurance Company to deny reimbursement based on medical necessity for health care that has been preauthorized, the division concludes that a medical necessity issue does not exist for this dispute.

2. Physician Management Services is seeking reimbursement for work hardening program services provided on date of service July 12, 2016, billed with procedure codes 97545-WH-CA and 97546-WH-CA. Indemnity Insurance Company denied these services with claim adjustment reason code 96 – "NON-COVERED CHARGE(S)."

The division finds that work hardening programs for this date of service are subject to the fee guidelines found in 28 Texas Administrative Code §134.204(h)(3). The division concludes that Indemnity Insurance Company failed to support non-payment of the services in question for this denial reason.

3. Physician Management Services is also seeking additional reimbursement for work hardening program services provided on dates of service July 13 and 14, 2016, billed with procedure code 97546-WH-CA. Indemnity Insurance Company denied these services with claim adjustment reason codes 15 – “PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER,” and 5225 – “PROCEDURE/SERVICES ARE DISALLOWED AS THEY ARE NOT AUTHORIZED.”

Submitted documentation includes a letter from Physician based Medical Management dated July 7, 2016. The letter provides preauthorization for a work hardening program of 80 hours/units for the left elbow injury. Indemnity Insurance Company’s denial for this reason is not supported.

4. The maximum allowable reimbursement (MAR) for the disputed services is subject to the fee guidelines in 28 Texas Administrative Code §134.204(h), which state,

The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs...

- (1) Accreditation by the CARF is recommended, but not required.

(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR...

- (3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

Therefore, reimbursement for the disputed services is calculated as follows:

Date of Service	CPT Code	Units	MAR	Insurance Carrier Paid	Amount Due
July 12, 2016	97545-WH-CA	1	\$128.00	\$0.00	\$128.00
July 12, 2016	97546-WH-CA	6	\$384.00	\$0.00	\$384.00
July 13, 2016	97546-WH-CA	5.5	\$352.00	\$16.00	\$336.00
July 14, 2016	97546-WH-CA	6	\$384.00	\$16.00	\$368.00
				Total Due	\$1,216.00

The total reimbursement is \$1,216.00. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,216.00.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,216.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
May 5, 2017  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**